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ABSTRACT

The paper describes a collaborative project carried out with staff of an IIWAS (Individual Instruction with Augmented Staffing) classroom and clinical staff of IJR (Institute for Juvenile Research) to provide educational and mental health services to 16 Black inner city children (10-12 years old) with low academic achievement and a variety of behavioral difficulties and symptomology. Goals of the program are outlined as demonstration of a model in which traditional treatment services and an academic program are coordinated in a public school, in which teacher and parent form a joint partnership aimed at enhancing the child's academic growth with the mental health clinician as a consultant to the teacher, and in which "filial" therapy is used to reengage the parents with their children. The presentation covers the following general areas: general descriptive material necessary to identify the special classroom, community and participants and an explanation of the program rationale; specific developmental stages of the program; techniques utilized to engage "unmotivated" parents in the academic process; the treatment modalities utilized to enhance and support emotional growth in a public academic environment; and the working relationship between teaching and clinical staff. (SBH)

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COORDINATING EDUCATIONAL AND MENTAL HEALTH SERVICES TO ASSIST THE BLACK INNER CITY UNDER-ACHIEVER

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM"

INTRODUCTION

Purpose of paper:

Introduction re: Public Law

To describe a collaborative project carried out with staff of an IIWAS classroom and clinical staff of IJR which demonstrates a model for implementing the (Public Law) requirements for provision of mental health services to students and for involvement of parents in the academic program.

The goals of the program included:

(a) Demonstration of a model of how traditional treatment services and an academic program can be closely coordinated in a public school, in order to maximize the child's growth.

(b) To demonstrate a model of how teacher and parent can form a joint partnership aimed at enhancing the child's academic growth. One element in this formula is a personal relationship between teacher and parent. The mental health clinicians' role was as consultant to the teacher around approaching and working with parents.

(c) To demonstrate one model of "filial" therapy, re-engaging the parents with their children.

The method of presentation chosen by the authors to communicate ideas and experiences around a combined service approach may be described as documentary and developmental. The presentation will cover the following general areas of data and experience:

(1) General descriptive material necessary to identify the special classroom, community and participants and an explanation of the program rationale;

(2) Specific developmental stages of the program;

(3) A report on techniques utilized to engage "Unmotivated" parents in the academic process;

(4) A report on the treatment modalities utilized to enhance and support emotional growth in a public academic environment;

(5) A report on the working relationship between teaching and clinical staff.

The IIWAS (Individual Instruction With Augmented Staffing) classroom is a special program planned in accordance with the Elementary and Secondary Education Act-Title I, Federal Regulation to meet the needs of identified pupils (1 1/2 years behind in reading) for readiness and reading instructions. The program guidelines mandate an augmented staffing pattern and joint inservice training for teachers and teacher aides conducted by program coordinaters. Stipulated in the guidelines for implementation are procedures for parental involvement.

The IIWAS calssroom is housed in an elementary public school located in the near west side community area of Chicago. The community is a predominantly Black neighborhood characterized by deteriorated housing, public housing projects, high unemployment, high delinquency, and high crime rates. There are limited support systems and the disorganizational character of the community has a debilitating affect on its residents.

In school year '76 - '77, most of the children placed in the classroom came from large singe parent families with a southern rural orgin. Primarily the families had difficult relating to the public welfare system on which they depended for survival goods and services. Some of the families had also been plagued by frequent involvement with legal authorities around delinquent and violent behavior involving older family members. Most prevalent among the families were the parent(s) difficulties in establishing meaningful social relationships, their inability to constructively manipulate systems which played a significant role in their lives, a sense of powerlessness in problem solving and in control over their lives, and a generalized sense of failure in themselves as parents. The majority of the parents were grammar and junio-highschool dropouts who acquired parenthood status during their adolescent years.

The children, in addition to low academic achievement, showed a wide variety of behavioral difficulties and symptomology. Among the descriptive characteristics were short attention span, aggression and withdrawal. The children had not developed socialization skills necessary to establish positive peer relationships. Some of them had frequent encounters with school authority figures as a result of negative attention seeking behavior. Generally the children had been perceived by school personnel as having emotional difficulties which primarily related to inconsistant nurturing in their familial environment.

The classroom's maximum capacity was 16 children who ranged in age from 10-12 years, staffed with a full time teacher and a half day teacher aid. The teacher was responsible for individualizing classroom instruction; interpreting program rationale to parents; encouraging and supporting parents willingness to become actively involved in the academic process. The teacher also felt that in order for any significant progress to occur, he would have to take on the responsibility for collaborating with other school personnel, community agencies and parents to assess related service needs.

As a result of the latter responsibility, the teacher began negotiating with the Institute for Juvenile Research - NWSYS Community Mental Health Team. The initial negotiation occurred late Spring'76 and program planning continued through late Summer, wherein the teacher and IJR clinical staff discussed program strategies that would incorporate mental health services as a integral part of the academic program. These services comprised an identifiable component primarily aimed toward the amelioration of psychological or psychosocial dysfunctions.

Several basic assumptions regarding parental involvement with the academic growth of children began to influence program planning. They included:

(1) Parents, including Black, socially and economically disadvantaged

ones, have high educational aspirations for thier children.

(2) Patents' active participation in the educational process is a source of stimulation and can enhance academic and social growth.

(3) Although the family and school are separate institutions, they share the responsibility for maximumizing growth potentials in children. Both are significant systems in which the child interacts and reacts and both can contribute to the perpetuation of problems.

(4) Parents, more frequently those who are considered intellectually limited and dependent, feel and are alienated b, large bureaucratic systems. Underneath feelings of isolation are hidden feelings of anger and disappointment in themselves as parents. These feelings are frequently acted out in the parent-child relationship.

These mutually shared assumptions between teaching and clinical staff advanced planning procedures to the second stage which involved stating objectives and program goals. By mandate, the overall educational program goal was to provide educational instruction that would enable the children to eventually function at or near the level in a regular classroom. Since these children had difficulties in their regular classroom placements, the initial objectives of the combined effort were of an assessment nature. They included making an early determination of possible reasons for each child's lack of academic success in regular classroom situations; an identification of areas in which there was a need for improvement; determination of social factors hampering social and emotional growth and academic progress; issues relating to parent

involvement, namely, their perception of the nature and reasons for the child's learning difficulties, determining their particular interest and capacities for potential roles.

The third stage of planning extended beyond but included previously stated assumptions and objectives. It involved identifying sources of information and techniques and approaches to be utilized in obtaining data for assessment purposes. The process raised several questions that have plagued many teachers and other helping professions. Among them were:

(1) What level of involvement could realistically be expected from parents who, by the complex nature of their life circumstances, historically have not actively participated in the educational process with their child(ren)?

(2) How can parents be motivated to engage in a constructive or supportive relationship with the academic institution?

(3) Do they have the capacity for change and growth?

(4) Can the parents be encouraged to mobilize often hidden internal resources?

The answeres to the questions would come from our meetings with the parents both individually and in the larger educational group.

One of the most crucial aspects in planning during this stage was the development of what teaching and clinical staff considered an effective approach to parents. Simple and direct approaches of letter writing, telephone calls and a parent questionnaire were utilized to engage parents. There was considerable effort put into content and even more in sentence structure. Each document was written in simple language and, in some instances, words frequently used by parents were incorporated instead of

concepts used by teacher and.or clinical staff. Content addressed and supported the assumptions that parents have high educational aspirations for their children and they can, through active participation, influence positive growth potentials.

Paramount to implementation of shared ideas and objectives was the differentiation of roles among staff. To arrive at a clear delineation, the process focused on tasks to be performed, on who was best skilled and qualified to do what and on mental health staff's availability to provide the needed therapeutic services. Trained clinical staff were designated for the coordination of clinical sercices with direct responsibility for the parent service component, diagnostic assessments of children, and clinical supervision of master and doctoral level social work students and para-professional staff who provided direct treatment. Supervising clinical staff also had responsibility for providing some direct therapeutic services to children and their families. A child psychiatrist was primary consultant to the teacher and functioned as key consultant in all scaffings on individual youngsters. A consultant on group treatment was available on a weekly basis to all clinical staff involved in the treatment aspect of the program and specifically those who utilized the group as a treatment modality.

The teacher's role was best defined by this statement of William Stark and Frances Bentzen: "The job of the teacher is to educate the young. To question the validity and importance of this goal, either directly or indirectly, is to attempt to change the goals of the profession rather than to clarify roles and teach the teachers who work with the child what the psychiatric profession knows concerning mental illness. There are then, two jobs to be done for the emotionally disturbed child in the school system. One is to teach him. This is the province of the school staff. The other is to

provide, to the best of our ability therapuutically sound measures to increase health and productivity." Having laid this groundwork for outreach and engagement, the combined staff then began its programs for parents and children both in groups and in individual treatment situations. The ramainder of this paper will discuss first, the involvement with parents; second, the treatment program for children in this class; third, the issues which therapists and teacher faced in this setting; and last the working relationship between school personnel and clinical staff which facilitated movement and direction in this program.

PARENTS

The staff person primarily involved with the parent component of the program was a clinically trained Black social worker who functioned with two basic premises. The first was that when parents are involved in a process that wili ultimately lead to the rendering of needed services for children, they too find that some of their needs are being met; secondly, when children's needs are defined in the context of parental aspirations, parents, including disadvantaged ones, are better able to understand and acknowledge difficulties and are therefore more willing to take the inherent risks involved in working with helping professionals.

Planning for collaborative work with parents, began prior to the beginning of school. This was a key goal of the teacher and IJR staff person. Letters were sent to each parent informing them of the child's placement and staff's combined effort to coordinate a wide range of services. The letter further requested a meeting on a specific date to discuss program rationale and structure and to solicit their cooperation in further planning as well as their active participation. Follow-up telephone contacts were made to each parent for

purposes of determining if they had received the letter, to give them an opportunity to raise questions regarding our intentions and to check out their availability to attend the planned meeting.

These initial contacts with parents of children assigned to the IIWAS classroom challenged the aforementioned premises in different ways. First there were several parents among the group who conveyed a level of functioning, in some areas, parallel to their children. More specifically this subgroup of parents elicited nurturing from staff through expressions of their needs for personal contact, for guidance and directions. It was apparent that their needs were primary to the educational needs of their children. These parents were generally self-doubting. They attempted to manipulate staff into assuming responsibility for practical matters in their lives. Secondly, most of the parents perceived helping institutions generally as unresponsive and were therefore antagnostic toward the educational system. The latter group of parents, although hesitant were the most receptive to attending the initial meeting but questioned their capacity to share in discussing educational issues. Questions raised alerted staff to some uncertainties the parents had in themselves. Behind those uncertainties were the fears of risking and of possible self-exposure.

The initial meeting was poorly attended. Consequently clinical and teaching staff put forth a concerted effort to make direct contact with parents on an individual basis. This intensive out-reach approach revealed several crucial issues which identified the parents more as a homogeneous group although there was heterogeneity of particular life styles and family circumstances. These same issues were viewed by clinical staff as negative forces that hindered constructive parental participation and cooperation with the educational system and adversely affected the academic process and emotional growth in the children.

The first and most pervasive factor among the parents was the impact of certain environmental conditions on their family functioning and the kind of adaptation they made. All of the parents were dependent on the welfare system for survival goods and services and they all lived, with one exception, in a public housing project. These two identified bureauctatic systems were perceived in ways as "functional parents" who set limits and controls which placed parents in a dependent, vulnerable position. Inherent in such relationships are implications of limited productivity, parental inadequacy and a poor self-concept.

In addition to the system parent/child entanglement, the parents were in a constant state of longing to belong, to be cared for and protected. Feelings of abandonment were expressed as a theme in the beginning and middle phases of the group process. These feelings were manifested through depressive moods, overt hostitlity and dependency. In some instances several parents exhibited erratic behavior, such as, panicked reactions to age appropriate behavior in children and forgetting to submit forms, required by public aid to re-establish eligibility for cortinued assistance.
Clinical staff directly involved in the outreach to parents became aware that these parents had undergone an immigration experience from the tightly-knit rural communities of close kin-ship bonds. Metropolitan Chicago, near west side community, plagued by crime, delinquency, over crowded housing conditions, unemployment - in short the Ghetto, was a contrast to the geography and environmental conditions of Delta and border-Delta area in Mississippi, rural Tennessee and farm land Arkansas. These communities from which the majority of the parents came were sparsely populated but offered them a sense of personal connectedness through biological and non-biological (play) relations. Most of the parents could spend hours reminiscing about their rural community, their particular life style which included working beautiful farmland, gardening, canning and sharing goods and services (better known to that particular pop-

ulation as borrowing and swapping). It became evident that these parents' roots were anchored in an environment which offered the nurturance and support necessary for continued growth. They were therfore mourning the loss of the sources of their self esteem; the loss of sources that expanded and enhanced their sense of identity and mastery. They were still mourning the loss of the supportive network needed in strengthening, maintaining and sustaining themselves. Extended family members of the parents who live in the Chicago area, and on whom they depended for social support also abandoned them. The reasons behind this abandonment are best stated by the parent who described the following, "When I first came to Chicago four years ago, I lived with a cousin on the southside. She didn't want me to talk around her friends, it was like she was ashamed of me or something. When she had house parties I had to stay in my room. I never went anywhere - not even to look for a job. She put me on A.D.C., then I had to give her my money. I wanted my children to come from down south, she said "no". She said I needed to go to school or some where to learn how to talk. All I wanted to do was to leave there. She helped me to get this place and I've been here since. She never calls or anything. I guess I'm too country for her now or maybe she thinks I'll ask for something. She's married and both are working." This account exemplifies a common experience of the parents. This lack of involvement with extended family members tended to intensify their grief and reinforce isolation. These parents had not established a new social network within the community through which they could learn of existing avenues that would contribute to self-mobilization.

Another common issue had to do with the parents perception of the educational institution as being highly intellectual and accusatory towards them. These parents were primarily grammar school or junior highschool drop-outs and were limited in their understanding and/or interpretation of concepts frequently used by professionals to convey opinions or concerns regarding

learning difficulties in children. Failure on the part of the teaching profession to recognize this difficulty had intensified parents' hostility and mistrust toward the school and other helping agencies. It had also posed a threat to the parents' educational aspirations for their children. Parents were therefore leery about initial contacts with the Institute for Juvenile Research and teaching staff.

While these were common issues among members of the group it was evident that several parents possessed hidden internal resources that could be vitalized and used constructively. Being aware of these strengths as well as the neediness of some parents, the clinical staff's weekly contacts were therefore task oriented. This helped to handle the dependency and mobilize growth potential in parents. The task often focused on constructive decision making and problem-solving.

The teacher's frequent contacts through telephone calls, individual meetings and simple written notes were educationally focused, primarily on sharing with parents the child's strengths, and the teacher's opinions regarding learning difficulties. Simple tasks that would stimulate the child's academic interest were suggested to parents by the teacher. He also offered the parents assistance in helping them understand specific assingments which increased their confidence in relating to their children around academic matters.

Active participation in the educational process was an area of great difficulty for parents. They perceived themselves as not having achieved the level of competance acceptable to the educational setting. Their previous experiences with the educational system were described as degrading and accusatory. Such negative encounters reinforced basic feelings of inadequacy in their parental roles. They acted out these feelings through a lack of interest in the educational process.

Through the intensive outreach and involvement of clinical staff with the parents, it became quite evident that most of them, in coping with environmental pressures, had compartmentalized their lives. Their energies were therefore tied to survival issues,

basic to their daily existence. Clinical staff recognized the existing pressures as real and offered support and assistance to parents in further partializing and priortizing problems so as to respond to the educational needs of their children. Through this joining process, staff came to know parents and were able to assess their potential skills and the varying degrees of emotional deficits in their parental functioning.

These activities on the part of the clinical and teaching staff tended to facilitate positive interaction between parents and the teacher from which a two-way exchange developed. More parents mobilized themselves and participated in the larger educational parent group through which specific parent roles and tasks were identified. The larger group meetings were held in the community in a model apartment of the housing project. This particular apartment was used as office space by the community liaison staff connected with the neighboring university. These meetings held outside the school setting allowed for more social interaction between parents. They therefore became a place for parents to establish a social network and at the same time share in the discussion of general educational issues with the teacher. Additionally, the group was a place for parents to collectively share with the teacher their ideas and suggestions about alternate ways to deal with day-to-day behavioral problems in the classroom. It also became a place for teacher and parents to pool resources to support and stimulate gains.

Through the larger group process, some of the parents were able to risk themselves directly in the classroom as tutors with the children. They tutored in a subject area where they felt competent. Again this was a difficult step for the parents, but they were able, at that point, to seek support from the clinical staff and teacher in their new venture. For example, one parent's high anxiety level prevented her from entering the classroom following her arrival at the school. She contacted clinical staff shared her anxiety and asked for assistance. This parent had spent long hours reading the night before. She wanted to be able to tell the children "a good story" but had left the book home. Fol-

lowing a brief discussion, the parent was able to enter the classroom and perform the task. This experience was not unique among these parents. Several parents ask for help in order to enter the larger parent group as well as to attend parent teacher conferences.

CHILDREN CLINICAL SERVICES

At this point it would be appropriate to describe the nature of the clinical services provided as well as some relevant characteristics of the children and families with whom we worked. While students in this program were often identified by school personnel as having emotional and behavioral difficulties, the criteria for inclusion in this class were specifically educational. This made the group somewhat distinct from populations of students placed in other special education classes, like those of the Early Remedial Adjustment (ERA) classes in the Chicago system which focused on behaviorally acting-out children. The IIWAS children were however, a heterogeneous group in terms of the difficulties contributing to their reading and learning under-acheivement. The majority of children had not previously received diagnostic services through the school system. Therefore, the early planning phase between the IIWAS teacher and the IJR consultant included an initial screening of children for whom more extensive diagnostic evaluations would be appropriate.

The initial sanction and request to begin this diagnostic process came from parents who were seen earlier in the school year

in joint conferences at school or in home visits with the teacher and an IJR staff person. These interviews occurred independent of the organizational meetings of the larger classroom parents' group, and were confidential. The teacher's role in these meetings was to act as a bridge between the parent and staff person. He shared concerns about the child, gave his opinions of the child's strengths and, shared his educational goals for the child.

In addition to this initial interview, the diagnostic process consisted of follow-up interviews with the parents and families, often in home visits; interviews with the individual children; and evaluation of the teacher's assessment of the child's learning difficulites, behavior in class, and compentencies. Previous psychological testing and psychiatric evaluation done by the special education staff at the school were used when these were available. Finally, the IJR clinical staff made classroom observations of the children. The children presented a wide spectrum of symptomatology. This included children showing overt clinical depression with withdrawal and regressive behavior; as well as children with severe impulse control problems and with low frustration tolerance. The class included children suffering from chronic illnesses such as sickle-cell anemia which resulted in behavioral difficulties. Some children showed infantilized and overly dependent behavior. Several children demonstrated pre-delinquent behavior. Finally there was another group showing no overt symptomatology in who intellectual or academic "retardation" might be conceived of as a specific symptom choice. In terms of peer relations, many children were socially isolated while others demonstrated competitive and antagonistic

relationships with one another.

Many of these children may be characterized as being high risk also, in the sense that they demonstrated inadequate cognitive, perceptual or visual-motor skill development. Their deficits in the ego-adaptive skills involved in information processing. Cognitive integration, and motor and language performance, made them more vulnerable to the stresses of developmental and environmental expectations. Many of these children had previously undiagnosed perceptual skill deficits. For some a pattern of secondary emotional disorder, that is poor self-concept, low acheivement motivation, low frustration tolerance, and poor emotional control followed their failures to perform successfully at school.

While there was great heterogeneity in particular life and family circumstances among the children, they shared certain common experiences. The majority of children coped with a wide range of neighborhood and family stresses. These included family circumstances where children had heavy responsibilities and where in fact, role reversals occurred with parents debilitated from chronic illnesses, alcoholism or drug addiction. Some families could be characterized as suffering from "underorganization". They demonstrated deficiencies in the degree of constancy, differentiations, and flexibility of the structural organization of the family system. Overall, these children could be characterized as "acting-in" rather than "acting-out" children. The majority of these late-latency and preadolescent children were actually functioning on a developmental

level more congruent with the skills of children at school entrance or very early latency. They demonstrated an object-hunger, an active seeking of adult attention and nurturance which was striking. These children had not yet disengaged from adults, nor had they made the kinds of adaptations to their learning failures sometimes seen in slightly older children that lead to self evaluations based on other kinds of skills and self-definitions that preclude serious application of their energies to learning. These children still wanted to please adults and elicit nurturance from them. This particular characteristic of the children's object relations had been commented on in the literature by Malone, Pavenstedt, and Minuchin, and others.

"There is a particular emphasis on manipulation to induce adults to act upon them. Helpless looks and gestures invites grownups to take over and do for them; misbehavior invites adults to move in and control them; teasing invites the punitive retaliation of grownups. The children are quite successful in inducing adults to unwittingly respond to their invitations and thereby repeat familiar patterns of their family interaction." (Malone Pg.30)

Our efforts to design appropriate interventions, took into account this predominant mode of child-adult interaction in class, in which the children actively engaged adults around controls, limit-setting, and dependent activities. The design efforts also took into account the tasks of the developmental phases that lead to learning readiness. Accomplishment of these tasks entailed the acheivement of basic trust, the acceptance of beginning inner and outer controls, the beginnings of autonomous functioning and finally the excercise of initiative. The child goes through a process in which the need to

be approved, to be accepted and rewarded is slowly turned into the love of knowledge and work and allows for internalization processes via the teacher's influence. Consultation to the teaching staff, interventions which supported parental involvement and direct clinical services to the children, were guided by awareness of this developmental process. In addition to the special education services previously initiated for a number of children with identified learning disabilities, as a result of the diagnostic process, five children were identified as needing individual psychotherapy with concurrent work with parent(s) or the whole family. It was felt that eleven other children would benefit from group psychotherapy. Others were receiveing speech therapy. More flexible access to the school's daily breakfast program was arranged for students who came to school hungry and whose inability to concentrate was related to poor nutrition. Also identified were children who would benefit from individual or small group tutoring provided by members of the classroom parents' group.

As a result of negotiation with the school administration by the IIWAS teacher, space was provided in the school for sessions with individual children and for two treatment groups. Efforts were made to ensure consistency in the room assignments and to ensure privacy and confidentiality of the sessions. As with many school - based treatment programs, there were the frustrations of working in less than ideal conditions and of coping with interruptions and room changes. At this time too, the school was particularly over-crowded as it was undergoing renovation.

The diagnostic and treatment services were traditional in

many respects. We were convinced that such services could be effectively provided because of the partnership between the teacher and individual parents. Treatment services were seen by parents as implementing their own goals for their child's educational growth. Thus, treatment was defined as a support of this process.

The individual psychotherapy consisted of bi-weekly sessions for most of the five children seen. It was basically a psychoanalytically- oriented play therapy focused on the development of a supportive relationship between therapist and child. Goals varied with each child but generally included the development of more autonomous functioning and initiative as the basis for learning. This functioning depended on the strengthening of internal controls, the further development of self-esteem, and the enhancement of learning related ego skills. These were the process goals of the therapy.

The testing of the structure which most children do in the early phases of treatment was particularly important to these children. The structure of limits, consistency of meetings, dependability and predictability of the therapist's responses, all helped to establish a framework in which children formed an intense relationship with one adult which eventually allowed them to strengthen internal controls. Sessions utilized play, work with a variety of materials, time- limited tutoring, and discussion of experiences at school and at home. The growing relationship between child and therapist supported the child's gradual attempts to master new skills and cope with the risks inherent in the learning situation. The effects of the enhancement in skills were slowly translated into changes in the classroom. Gradually, as increased internal controls

allowed them to concentrate, children demonstrated more initiative in learning and capacity to produce. Teacher and parents carried over the relationship supports in class, reinforcing the children. Learning began to be a more autonomous activity which slowly developed its own rewards as the children experienced pride in their efforts and the intrinsic pleasure of mastery.

This carry over of treatment gains into new learning behavior was also apparent as a result of the treatment groups. As an example, we will describe one of the treatment groups used in the project which was a short-term group of four boys aged 11-12 years. There were two therapists leading the group, an experienced Black social worker and a first year White social work student. The particular common difficulties the boys exhibited were: (1) withdrawn and listless behavior, (2) they could not focus on specific task or work in a sustained manner, (3) their relationships with adults aimed at eliciting nurturance, or manipulating adults into doing things for them, (4) overall, the childten's dependency needs with adults had not been met to a sufficient degree, to allow them to move on to gratifying peer relations, (5) there was a general distortion about appropriate adult roles in their lives. Adults were seen as objects of potential gratification, who when frustrating, were seen as bad, dangerous, and punitive. They could not differentiate adults as separate people as other than need-gratifiers. Real environmental dangers reinforced these views of adults. Most of the children showed a real deficit in the level of their object relations. Therefore, goals of the group were to: (1) increase the children's

verbalization about these issues, (2) provide an experience with reliable, consistent, nurturing adults in a structured task-oriented situation, (3) help them move from a dependent relationship with a consistent adult to one where they use the adult to guide and support more independent functioning around a learning task, (4) help them learn to cooperate and share with one other child, and later with a small group of peers, (5) use the tightly structured group situation and norms to help them internalize better controls over their own behavior, (6) help them form social relationships both by using dyads and the full group situation, (7) provide a setting for playing out and more appropriately handling their own aggression.

Materials chosen to focus group interaction were a lego block police station. The police station and the figures represented authority. Through these, the children would be able to describe what adults represented in their lives. These included themes about their need for protection, nurturance and parenting, a view of the teacher as one who guides, gives directions and structure. The police station materials elicited thems about the children's fears of danger, of being harmed or destroyed by violence. A powerful theme throughout was their fear of being rejected and abandoned by a protecting adult with whom a close attachment had been formed.

Initially the children role-played their fears around violence by staging an accident that called for the need for

medical attention, They judged the vehicle at fault and decided whether the driver should be punished. The policeman (authority figure) was portrayed as non-caring. He acted matter-of-factly, disregarding the severe injury. At the end of the structured group process, the children identified levels of authority among policemen and each level was acted out according to their perception of the specific responsiblity. This activity was in preparation for a project they planned for their peers in which a policeman would be invited into the classroom. In role playing this situation, the children identified the teacher as a constant, and reliable, figure. They were able to identify the more nurturing, protective aspect of the policeman's role.

By the close of the eight sessions the following gains were noted:

(1) The boys were able to manipulate the materials in more creative and less compulsive ways.

(2) The boys were able to use both verbal and visual directions to direct others.

(3) Certain children obviously were no longer withdrawn and listless. The most withdrawn was actively taking real pleasure in reading independently. This child's parent was actively involved in the classroom. Through staff contact with the family, it was evident that the structure of the program had a positive impact.

(4) Children did in fact verbalize, through storytelling,

some of the frightening experiences they'd heard about, observed in the neighborhood or members of their families had experienced.

(5) The boys verbally expressed their desire to carry this experience out of the group and into the classroom by helping other classmates to learn to listen and talk to each other, thus become Fixers. (the name they had given themselves)

The storytelling expressed the fears of the children around the beginning of a group experience and contributed to group cohesion by the affective sharing that went on. This was psychologically useful in ways of reducing anxiety, putting boundaries around the experiences, doing some reality testing with the adults, and in general, freeing energy to learn.

The follow-up to this group experience was ten(10) monitoring sessions held in the classroom once weekly during the spring quarter. The entire class worked on craft projects in small groups. The emphasis were once again on learning to complete a task and at the same time to relate to peers (in conversation and manipulation of materials).

The role of the therapists in the monitoring sessions was to provide support to group members in their modeling roles among their peers, to enhance the gains that the group members had achieved through the group experience, and to facilitate the integration of these learned social skills, making it possible for them to engage in gratifying peer relations.

The group members often took the initiative in helping

other classmates by giving directions or working with them to master the materials. Emphasis was placed on completing the task at one's own pace and on asking for or giving help. Thus the entire class became fixers.

This model of using group members and their personal and collective gains to stimulate new patterns of behavior within the classroom setting was found to be very effective. The original group members maintained and strengthened their therapeutic gains by transferring skills learned in the group setting to relations with peers in the classroom. The class benefited by sharing in and beginning to use the same behaviors.

THERAPIST ISSUES

Some of the identifiable issues which the therapist faces in this type of program could be categorized as:

1. The difficulties of the setting, i.e. space, confidentiality, the academic emphasis;
2. The different roles therapist is asked to assume within the one setting;
3. The environment of the setting, and
4. The neediness of the children.

Adapting treatment to a school setting, and in this case to a school undergoing remodeling, was often a frustrating experience. Space was at a premium and establishing consistency via a treatment room was nearly impossible. Moves from session to session as well as within a single session were a reality which had to be dealt with.

Confidentiality had to be carefully safeguarded because of these interruptions and disruptions. Questions asked by children

in the class and school staff had to be fielded in such a way that the integrity of the sessions was protected.

The inherent pressures of being in an institution where academic learning was the prime focus and treatment would only be allowed to intrude in order to further the process of learning, were real.

Maintaining open communication with all school staff was a factor vital to keeping the program alive. As much a part of the system as we became, we were still on "foreign soil".

Not only was there the obvious tension because of role differences between the educational and treatment staff, but there w was also a need on the part of therapists to change roles in dealing with the same children within the same setting. For example, one social worker who was seeing an individual child for long term intensive treatment, had been co-leader of the group of four, and was one of the clinical staff working in the mointoring sessions. This meant not only a shift in how she related to the children, but also a shift in how they were called on to relate to her. Her cues to them had to be clear and appropriate so that they could respond in a manner which fit each situation. For example, a child being seen by a therapist in individual sessions had to relate to her differently during the monitoring time. She had to help him understand that this time was for class interaction and not the time to work on his issues making use of their established therapeutic relationship.

A third issue was the impact of certain environmental conditions on the therapist. The poverty, the deterioration, the obvious material and psychological needs which the situation created, led the

therapist to an initial feeling of helplessness--of being overwhelmed. This experience can be useful to any clinician. It is in essence the experience of the people he/she serves. The therapist tends to compartmentalize and shut out certain aspects of the environment as the people themselves do, in order to achieve a focus which frees energy for coping and adaptation.

For many of the people who live in this environment there are few opportunities for gratifying experiences. Their energies are tied to basic survival tasks. In the case of the therapist, though the total neighborhood was overpowering, the nature of his/her role enabled him/her to focus on the tasks to be accomplished with children and staff. Individual case assignments allowed the therapist to mobilize their particular skills and relate humanly to the particular child or family with whom they were working.

The last issue, which also had an overwhelming component was the neediness of the children. It was neediness paired with an openness to intervention. The children overtly reached out to therapists for attention during their presence in the classroom. It was not unusual for several children to touch or even pull therapists over to spend individual time, even though they were aware of this time being for specific children. Children would also ask permission to come into individual and group sessions. Therapist therefore, felt the pressure of a "ready moment" for with the one set of adolescence the various developmental deficits of these children would be more -

likely to take their toll. It was obvious that these children had not yet given up or given in, but they were also running out of time.

With a program like this many of the same issues and feelings triggered in staff by day hospital, residential, or other milieu experiences are felt. Similarities included intensity, amount of time spent, close inter-dependency of staff, and the need to communicate often and clearly about children's behavior. For example, the objectivity necessary for effective therapy became more of a challenge because of the therapists' exposure to the children's behavior in class and in the neighborhood. This broad exposure made the therapist acutely aware of impairments and deficits, as well as the child's areas of competence.

Likewise, there were issues which the teacher faced in this program. These included:

1. The level of commitment of treatment staff;
2. Safeguarding educational goals;
3. Experience and class size.

Much too often, the difficulty in providing clinical services in a school setting is due to the lack of trust between professions. This was quite evident in the initial phase of planning in this program. The main concern the teacher had was around being left holding the bag of services. Would clinical staff be consistant in responding to treatment demands; and would they follow through? Open discussion of these concerns was a turning point in the relationship with the consultant.

The inherent pressures from the system of having responsibility for the educational goal became more evident. The academic process could not be seriously interrupted by the inclusion of therapy. It was therefore necessary to plan and structure the academic curriculum to allow for the needed intervention.

This project would have been an impossible task to accomplish without the teacher having experience in the system; having a small class; and having additional supports from the school structure. With a larger number of children, the time spent calling parents and arranging for time with the consultant, would have been difficult. It would have also been difficult for the teacher to be consistant in contacts with parents. Thus, this program perhaps would not be possible within a regular classroom.

Balancing all of these factors was possible because of the mutual support experienced within the educational and clinical team as well as consultation and supervision.

WORKING RELATIONSHIP

The process through which program planning occurred was crucial to the development of an ongoing working relationship between staff. Although the initial base was a mutual desire to meet the needs of the children; there were other crucial enhancing factors. One of these was the nature of content in the beginning phase. Issues discussed were unrelated to the teacher's role or his relationship with "troubled youngsters." This offered some safeguard against what some clinicians call "disorganizing teacher-anxiety." The chosen content facilitated sharing of beliefs, professional styles and

approaches, and some basic professional knowledge.

Another contributing factor was a sense of respect between professions. It was always necessary for clinical staff to accept and plan sessions mindful that the academic goal was primary. It was also necessary for clincial staff to accept frequent space shifts for sessions. On the other hand, it was incumbent upon the teacher to develop and maintain a structure that would allow students to be dismissed for sessions without seriously interrupting or interferring with the academic process. Flexibility was the key. Each staff person expressed opinions and frustrations openly without feeling a need to defend professional positions. Communications depended on noncritical and nonjudgemental attitudes.

Weekly meetings were held between the teacher and psychiatrist. These meetings focused primarily on general developmental issues and on behavioral dynamics. Clinical staff involved with direct treatment of individual children met with the teacher on a regular basis to share pertinent material that aided in better understanding the child's needs. This time provided a two-way exhange between both disciplines, which aimed at pooling information and observations so that treatment and education could better focus on the child's needs. Consistency was therefore a crucial factor in maintaining an open line of communication throughout the school year and was most essential in the beginning stage of planning.